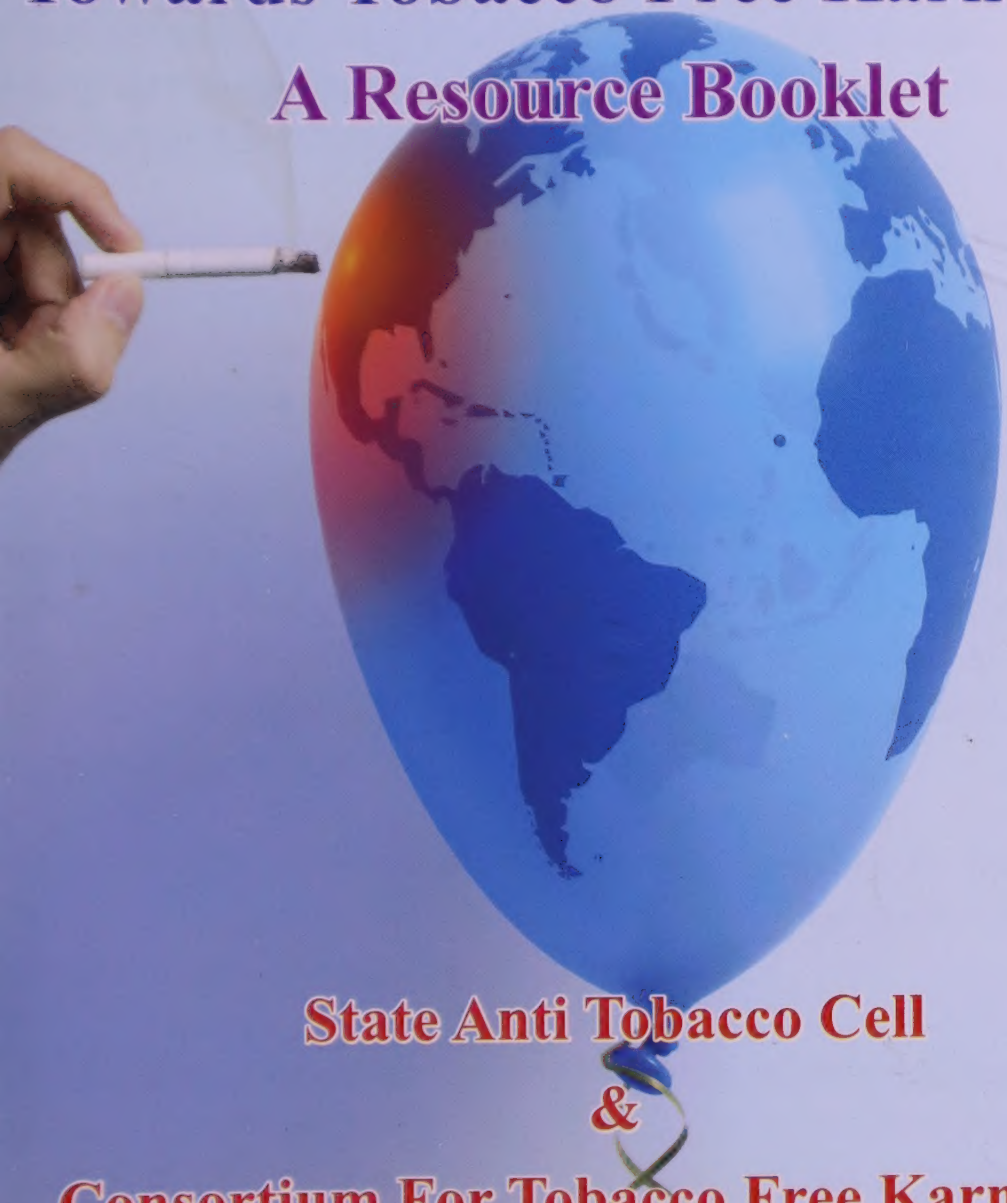
TOBACCO THREATENS US ALL

Towards Tobacco Free Karnataka

A Resource Booklet



State Anti Tobacco Cell

&

Consortium For Tobacco Free Karnataka

SAY NO TO TOBACCO

PROTECT HEALTH, REDUCE POVERTY AND PROMOTE DEVELOPMENT

World Health Organization

FCTC WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL SECRETARIAT

TOGETHER LET'S BEAT NCDs

SUSTAINABLE DEVELOPMENT GOALS

31MAY:WORLDNOTOBACCODAY #NoTobacco

Foreword

Tobacco is certainly a threat to development as the World Health Organisations announced it as a theme to focus for the year 2017 and is inviting all the member countries and civil society organisations plan their actions around the theme.

It is Heartening to know that Directorate of Health and Family Welfare Services, Government of Karnataka, Bruhat Bengaluru Mahanagara Palike (BBMP) and civil society organisation are coming together to address the challenges to tobacco control in Karnataka. Recognising the magnitude of the problem related to tobacco use the Health and Family Welfare Department, Govt of Karnataka has formed the Anti Tobacco Cell before the launching of the National Tobacco Control Programme. The District Anti Tobacco Cells have been established and are empowered to create awareness on ill effects of tobacco across all section of the society, particularly among the students as they are more vulnerable to experiment with tobacco products.

Besides the enforcement drives that are being carried out from time to time to take action against the violators of COTPA; The government also has banned the use of e-cigarettes as it is harmful.

Social support is crucial to the success of the tobacco control initiatives in the state. It is my hope that more health care institutions and civil society organisations would join the efforts by government to implement all the activities successfully to achieve the desirable results.

I wish the tobacco control initiatives in Karnataka success in all their endeavours.

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EDITORIAL

Tobacco is one of the leading causes of preventable disease and death in our society. Over the years its tentacles have spread far and wide, holding society in its vice-like grip. Hence WHO has declared 31st May of every year as 'World No Tobacco Day'.

A country that sees ten lakh preventable deaths and many times more morbidity annually needs to take urgent action to remedy the situation. Hence this day is a great opportunity to raise awareness and kick-start efforts towards the cause. At the same time, it isn't enough to pay lip service to the cause once a year and consign it to the periphery of memory for the rest of the year. Year-round efforts towards reduction of demand as well as supply of this malevolent product is of utmost importance and equally important is for the society to cautiously antagonise tobacco lobbying activities.

The theme for this year is 'Tobacco- a threat to development'. The word development is often associated with economic activities, but quality of life is also an important facet of progress. A product that causes such mayhem has no place in an enlightened society. It adversely affects everything from the health of the users, the financial situation of the family and even the ecosystem. It stands to reason that any population where one-third of the adult members actively consume a potential carcinogen cannot become stronger without addressing the issue urgently. Hence this year's theme is very apt, especially in the Indian context.

On this World No Tobacco Day, let us all take a pledge to work together towards ending this menace in society and tossing tobacco into the dustbin of history where it belongs.

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Tobacco and development

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What is development? In the present context, one could define it as the growth and advancement of civilisation. It means more freedom, equality and prosperity to all. It means better health care and education. Development is a sweeping word that encompasses all the changes that make society a better place to live in. As citizens it is our obligation to contribute in any way possible to this exalted pursuit.

Does tobacco have a role in developing society?

Let us examine this question in detail. Tobacco is a habit-forming carcinogen being produced, packaged and sold for consumption as a life-style product. It offers neither nourishment nor remedy. It is produced solely for profit, and its only effects are destruction of the body and enslavement of the mind.

So does it have a place in our society?

The industry argues that it provides huge revenue to the government while also giving employment to millions of workers as well as farmers whose livelihoods depend on this crop. They say it is a legitimate business governed by a Tobacco Board that was created for the specific purpose of regulating its activities. 'Sure it is harmful' they admit, before quickly adding, 'but the packet carries a warning. Nobody forces anybody to buy the product. People do it of their own free will'.

These may sound like silly arguments to any rational person, but they need to be addressed nevertheless, if only to remove any misconceptions people may have.

Let us consider the first argument. Is it legitimate to argue that ten lakh people need to die for many others to make a living? One wouldn't be wrong to doubt the moral compass of a person who says it is. Moreover a positive

economic impact of the tobacco industry is a myth. A cursory glance at figures proves otherwise. According to a MoHFW report published a few years ago, the total costs attributable to tobacco-related diseases in 2011 was Rs 1,04,500 Crores, of which 16% was direct and 84% indirect. Direct refers to medical costs, whereas indirect refers to loss of income due to death and disability. The revenue earned by the state from tobacco taxation, on the other hand, amounts to a measly 17% of the total cost burden. It is absurd enough to sweep death and disease under the carpet in order to earn revenue, but even the economics of the whole affair sounds overwhelmingly ridiculous. The fact of the matter is tobacco is excessively profitable to a select handful of very powerful people, and over ten lakh families pay the price for their collective greed.

The second argument is at first a little tricky. The constitution provides for a board, hence tobacco is a legitimate business, they say. But who wrote the constitution? Why men, of course. These were not handed down to us by divinity. These laws were man-made. And man-made laws need to be changed with time, in light of fresh evidence. And it must be said the body of evidence accumulated against tobacco over the forty years since the formation of the board has been pretty damning. If curbing this menace requires amending the laws, then maybe it is time to do so now rather than later.

Now, let us speak about tobacco and free will. Do tobacco users have free will? Research has shown that tobacco is one of the most addicting substance known to man, defeating such worthy rivals as cocaine and heroin. Withdrawal symptoms are debilitating and excruciating. Quit rates are abysmal, somewhere in the range of five to ten percent. How many smokers do we know that desperately want to quit but cannot? Does this mean most of humanity is weak willed? Or maybe we should think of another explanation? Perhaps these men and women are not abusers, but rather victims of this vicious drug?

Mind you, we haven't even begun to speak about the diseases it causes, the suffering it inflicts on the victims, the emotional and economic burden it places on their families or the ecological disasters perpetrated in making it smokable and palatable.

So does tobacco have a place in the development of human society?
It's time civilised society decided for itself.

THE BIG TOBACCO MONEY- WHO WINS AND WHO LOSES?

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The tobacco market in India is worth over 90,000 crores. In today's world, India has emerged as the second largest consumer and third largest producer of Tobacco. We export to over 100 countries and cigarette accounts for 85% of all exports out of India.[1] The combined tax revenue collected annually from tobacco products is more than Rs. 31,000 crores which is the second largest central excise revenue next to oil and gas.[2]

Tobacco is the only cash crop that kills among other non food crops. The addictive nature of tobacco traps its users to be long term customers. The huge money contributed by the tobacco users is what attracts many players which include tobacco farmers, tobacco companies, government agencies, and political parties etc.

Who Wins?

The cigarette and bidi companies

Though the legal cigarette consumption in India accounts for only 11% of the smoked tobacco, the market value is huge, worth more than 10 billion.[3] There are about 36 cigarette manufacturers in India.[4] Despite smoking ban and other tobacco free initiatives the tobacco giants are making profits in India. Lion's share of money from tobacco is always enjoyed by the tobacco companies. The least goes to the farmers and other subsidiary workforce in industry including the bidi industry.

The bidi industry in India employs about 5 million workers in the age group of 15-60 and 90% of who are women. They roll 7.5 billion to 1.2 trillion sticks annually. The market value of bidi industry is about 7500 crores.[5] Despite the low wage, women do the bidi rolling as it is home based. There are about 240 bidi manufacturers in the country. The primary employers are in the following four states- Karnataka, Maharashtra, Madhya Pradesh and West Bengal.[6]

The smokeless tobacco companies

The market value of smokeless tobacco in India is over 8 billion.[7] The global market value of smokeless tobacco is 14 billion of which India and US share about 84%.[8] Asian style of the chewing tobacco is highly sold in India and includes gutka, zarda, khaini and mawa. There are about 400 brands of chewing tobacco being marketed in India.

The government and political parties

As the tobacco trade is legal in India, the government gets about Rs.31,000 cores from central excise, state taxes and exports. Tobacco companies too contribute to political parties. Only ITC has disclosed the amount contributed to various political parties. The political parties have not disclosed the proportion of their funding from tobacco companies in their unknown source of funding in crores. Given this scenario, who's cause will they defend?

Besides this the Public Sector Units are investing in shares of tobacco companies. Recently the Voice of Tobacco Victims, exposed Life Insurance Corporation (LIC) and Unit Trust of India (UTI Limited) had a large chunk of shares in cigarette companies like ITC and VST.[9] This is violation to the commitment the government made to the Framework Convention on Tobacco Control (FCTC)

Who loses?

Tobacco products users and their families

It is estimated that about 276 million Indians use tobacco in some form. There were 120 million smokers in the country of whom about 69 million people smoked bidi, the remaining were cigarette smokers.[10] There are about 163 million smokeless tobacco users in the county.[11] A pack of cigarette cost Rs.123 to 250, a bundle of 25 bidis cost about Rs. 12 and smokeless tobacco sachets cost between Rs. 2-10.

About 50 percent of India's children are malnourished, and a study conducted by Naandi Foundation reported an even bigger menace of adult malnutrition. How does one justify an individual's freedom to blow up the money for tobacco products in this context? Before killing its victims, the tobacco products cause debilitating illness which cost the nation and the individual a huge health care cost. In India about 10 lakh people die due to tobacco related illnesses every year. The total economic cost attributable to tobacco use from all diseases in the year 2011 was estimated at 1,04,500

crores, while the approved budget for ministry of health and family welfare in 2016-17 is 37,061.55 cores.[12]. Who meets the huge out of pocket expenditure? Will the tobacco companies share from the lion's share they enjoy?

Passive smokers

About 30% of the adults are exposed to second hand smoke in indoor workplace, 11% in restaurant and 17 % in public transport. About 37 % adolescent are exposed in public places and about 21% at home are exposed.[13] There is no safe level with passive smoking as it is also equally harmful as smoking. It is illegal to smoke in public places in India yet passive smoking is tolerated due to ignorance on the harmful effects of tobacco, as a result they tolerate smoking and indicate social acceptance.

The farmers, farm labourers, Bidi factory workers, tendu leaf pluckers, and trade retailers

According to tobacco institute of India, tobacco is a source of livelihood to about 45.5 million people who belong to the above mentioned groups.[14] The breakup of these figures are not substantiated by authentic data. The farm labourer suffers from green tobacco sickness, and the bidi workers suffer from many occupational hazards for a meagre income. Will the tobacco companies meet the health care cost of these workers?

The way out

World Health Organisation exposed tobacco companies?

The WHO being aware of the health implications through various research findings, suspected the role of tobacco industry. In 2000 AD Dr. Gro Harlem Bruntland, Director General of WHO then set up an enquiry at the WHO to see if tobacco companies had infiltrated the organization. The enquiry revealed top executives of the tobacco industry sat together to design and set in motion, elaborate strategies to subvert the WHO. Dr Bruntland was furious when the truth was exposed and she responded *"I am a doctor. I believe in science and evidence...tobacco should not be advertised, glamorized or subsidized"*. She said *"do what it takes to expose the tobacco industry and ignite and catalyze public health action"*. Followed by this she has initiated the first ever Public Health treaty- Framework Convention on Tobacco Control (FCTC) on any health issue using the constitutional prerogatives of WHO. India is one of the first few countries to sign the treaty.

Government is leading the action supported by civil society organisations

While the Health ministry of the government is leading the way to implementation the recommendations of FCTC, the ministry of commerce, industry and agriculture are soft in their stand. The health care institutions and civil society organisation are supporting the health ministry to implement tobacco control measures; the key to win the battle lies in the social mobilisation.

The tobacco companies capitalise on the large social approval, money power and political support to continue the reign in tobacco trade, but it will not last long. Certainly tobacco companies are aware of their imminent defeat and they are fighting tooth and nail, as by 2020 the tobacco cultivation has to be reduced to half according to FCTC commitment which will make a huge dent in their profit margin.

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ROSE CAMPAIGN – A CAMPAIGN FOR TOBACCO FREE EDUCATIONAL INSTITUTIONS.

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Background and Rationale:

Tobacco has emerged as one of the major public health threats killing approximately 6 million (60 lakh) people each year globally, of which 80% of the deaths are likely to occur in low and middle income countries.

As per Global Adult Tobacco Survey(GATS) 2009-10, conducted by Ministry of Health and Welfare, Government of India in collaboration with WHO and CDC reveals that,35% of adults (age group of 15 and above) consume tobacco andin Karnataka 28% of adults(age group of 15 and above) consume one or the other form of Tobacco. It means close to One and Half Crore Karnataka Population consume Tobacco Products.Age of Initiation of Smoking in Karnataka is 18 years and Smokeless Tobacco is 17.5 years.

A similar study for youth titled the Global Youth Tobacco Survey (GYTS) captured data pertaining to tobacco useamong 13 – 15 year old children. The comparison of the two GYTS done so far reveal the following;

Parameter	GYTS - 2006	GYTS - 2009
% currently use any tobacco product	13.7	14.6
% currently smoke cigarettes	3.8	4.4
% currently use other tobacco products	11.9	12.5
% of never smokers are likely to initiate smoking next year.	15.1	15.5

Tobacco Industry targets youth/students to increase their consumer base which depletes over time by mortality or morbidity of the tobacco user. The above tables show that the prevalence of tobacco use among the youth has increased.

It is also evident that, availability of tobacco cessation services is limited and hardly known to the common public in India. Therefore, the best way of preventing problems related to use of tobacco is to stop initiation of tobacco consumption among youth.

The Cigarettes and Other Tobacco Products Act(COTPA) 2003:
Indian Tobacco Control Law i.e: COTPA 2003 section 6(b) prohibits sale of tobacco products within the radius of 100 yards of any educational institutions. But, many Points of Sale are still continuing the sale within radius of 100 yards of educational institutions. Many Points of Sale owners are unaware of the law.

With this above rationale and background, State Anti Tobacco Cell, Bangalore, Department of Health and Family Welfare Services, Karnataka has come up with innovative campaign called 'Rose Campaign – a Movement for Tobacco Free Educational Institutions'.

Objectives of Campaign:

- To bring awareness on Ill effects of Tobacco Consumption and provisions of COTPA Section 6(b) to Tobacco Sellers who sell tobacco within 100 yards of Educational Institutions.
- Creating enabling environment to enforce COTPA 2003, Section 6(b) for Tobacco Free Educational Institutions.

Figure 1: Rose Campaign in Bagalkote District

How is it innovative?

- Single campaign reaching many stakeholders like students, Youth, Teachers, Parents, Law enforcers, and Tobacco Sellers.
- Cost Effective
- Campaign where all schools and Colleges of a district participate simultaneously on single day
- Involvement of multi level stakeholders i.e. law enforcers from Government department (police, education, health, etc.),Civil Societies and Media to generate public awareness on ill effects of tobacco consumption and tobacco control law.

Figure 2: Jatha by students

Rose Campaign - is an innovative Campaign led by Students and Teachers for Tobacco Free Educational Institutions. India's first District wide campaign for tobacco free educational institutions involving all the educational institutions and students. The students visited tobacco shops in the district who are selling Tobacco products within 100 yards of their educational institution through Jatha. They handed over a Red Rose (symbol of love and respect) along with a handout which explain objective of campaign, sensitizing tobacco seller on ill effects of tobacco consumption.

Figure 3: Students handing over Rose and handout to Point of Sale owner

Below flow chart explain on how this campaign has been implemented in the district:

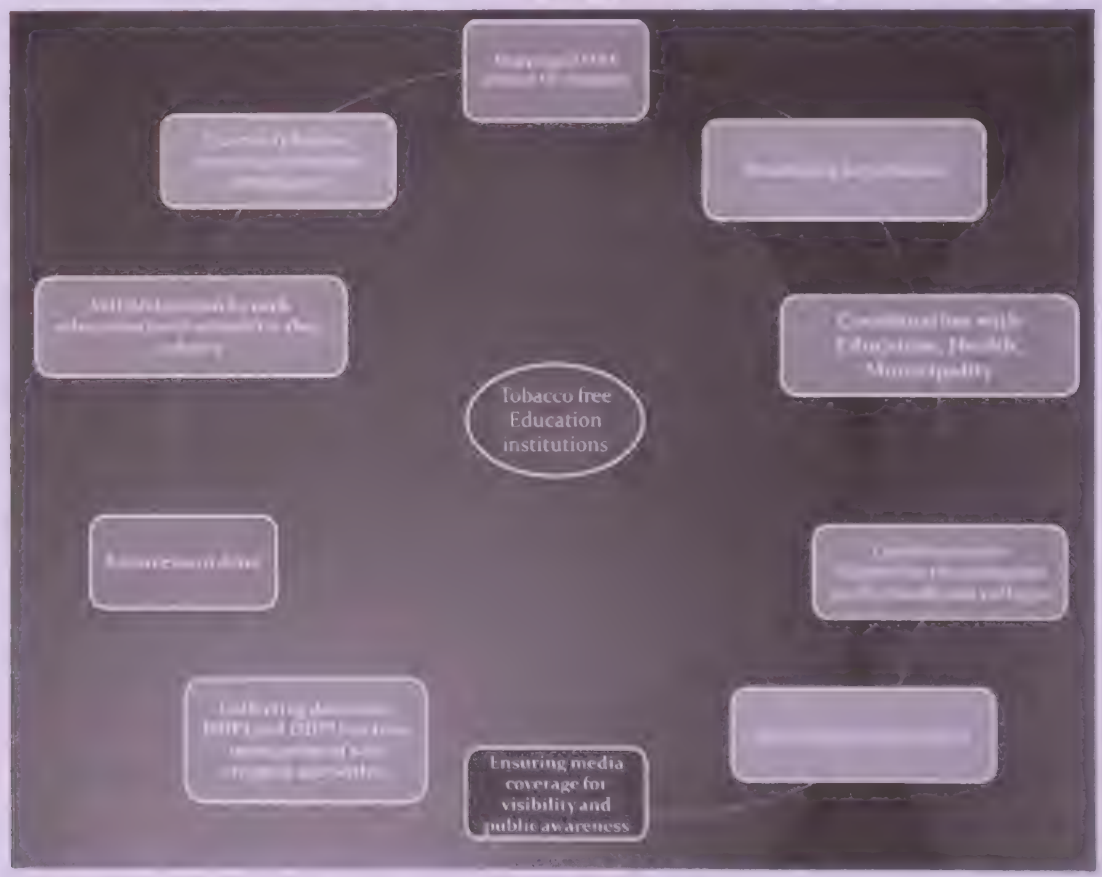

Figure 4: Rose Campaign in Hassan District

Review and Enforcement

- After 15 days of Campaign, Schools and Colleges reviewed the impact of Campaign.
- Conducting Enforcement drives through Police, District and Taluk Squad on those who continue the sale within 100 yards of Educational Institutions.
- Education Department certifies how many schools and colleges have been declared as Tobacco Free Educational Institutions
- Health Department (State Anti Tobacco Cell and District Anti Tobacco Cell) reviews the status and provides necessary support to sustain the compliance.

Reach: In four districts rose campaign has been conducted so far. More than 20000 students and teachers were involved in the campaign. More than 500 Point of Sale owners were confronted directly and sensitized. Good publicity was made through print and electronic media.

Conclusion:

In Karnataka, Rose Campaign has been considered as an important IEC tool for Health Education especially in Rural Karnataka. It will be conducted in all districts to educate public on ill effects of Tobacco consumption.

Best Practices in Tobacco control

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Introduction and Rationale:

Tobacco is the foremost preventable cause of death and disease in the world today, killing half of the people who use it. Globally, it kills nearly 6 million people, of which nearly 0.6 million premature deaths can be attributed to exposure to second hand smoke (SHS). If current trends continue, tobacco use will kill more than 8 million people worldwide each year by 2030. Over the course of the 21st century, tobacco use could kill a billion people or more unless urgent action is taken. As per the Report on Tobacco Control in India (2004), nearly 8-9 lakh people die every year due to diseases related to tobacco use.

National Tobacco Control Programme (NTCP)

The National Tobacco Control Programme was launched by the Ministry of Health and Family Welfare, Government of India in 2007- 08, during the 11th five year plan, with the following objectives:

- To bring about greater awareness about the harmful effects of tobacco use and Tobacco Control Laws.
- To facilitate effective implementation of Tobacco Control Laws.

State Anti Tobacco Cell, Karnataka

State Anti Tobacco Cell, Karnataka (SATC) has been established in the Directorate of Health and Family Welfare services. The SATC is responsible for overall planning, implementation, monitoring and evaluation of the different activities, and achievement of targets planned under the National Tobacco Control Programme in the State. It is headed by Secretary, Health & Family Welfare Services and is functioning under the guidance of Joint Director (Medical) who is the State Nodal Officer, Tobacco Control. The cell primarily focuses on planning, monitoring, implementation, IEC activities etc in the light of COTPA (Cigarette & Other Tobacco Product Act-2003) and FCTC (Framework Convention on Tobacco Control) provisions. This is

achieved through establishment of District Anti Tobacco Cells (DATCs) across the 30 districts of the State that includes all key stakeholders cutting across various departments including village panchayats and Principals of schools.

State Anti Tobacco Cell - Bloomberg Initiative:

Since 2013 -14, Government of Karnataka, Health and Family Welfare Department implementing a project called **"Effective Implementation of Tobacco Control Laws in Karnataka by Capacity Building and Monitoring"** funded by Bloomberg Initiative with the technical support from International Union against Tuberculosis and Lung Disease(The Union), New Delhi. Currently project being implementing in non NTCP districts (14 districts) since January 2016.

The key mission and goal of the initiative was "To facilitate effective implementation of the Tobacco Control Laws in state and to bring about greater awareness about the harmful effects of Tobacco use among masses".

Progress and Achievements of Tobacco Control Programme from 2013-2017

Institutional Set Up:

- National Tobacco Control Program(NTCP) had been launched by Ministry of Health and Family Welfare, Government of India in 2007- 08, during the 11th five year plan.
- NTCP was launched in Karnataka in the year 2007- 08. It has been integrated with National Health Mission (NHM) since the year 2014-15. The 18 Districts selected for NTCP are Bengaluru Urban, Kalaburagi, Kolar, Yadgir, Koppal, Dharwad, Shivamogga, Tumakuru, Mysuru, Dakshina Kannada, Vijaypura, Belagavi, Gadag, Raichur, Bellary, Bidar, Bangalore Rural and Udupi. Key activities under National Tobacco Control Program are setting up of Tobacco Cessations Centres, Schools Programs to build awareness on ill effects of tobacco consumption, IEC and Enforcements.
- State level Steering Committee has been set up under the chairmanship of Principal Secretary-Health and other key officers from various departments.

- *Established High Power Committee for Tobacco Control in Karnataka under the chairmanship of Chief Secretary, Government of Karnataka to review the tobacco control program and to give strategic directions for effective implementation of Tobacco Control Program.*
- *In all 30 districts, formed District Anti Tobacco Cell(DATC)s and District Squad Team for effective implementation of Tobacco Control Program.*
- *Karnataka booked highest number of COTPA violation cases during 2016-17 in India followed by Kerala.*

January-December 2016		January-December 2015		January-December 2014		January- December 2013			
Penalty Amount (Rs)	Number of cases booked	Penalty Amount (Rs)	Number of cases booked	Penalty Amount (Rs)	Number of cases booked	Penalty Amount (Rs)	Number of cases booked	Section	Sl No
16051276	146832	20945363	149519	15972122	127163	4253830	34426	Section 4	1
423800	2119	393800	1969	806400	4032	567400	2857	Section 6	2

Achievements:

1. To reduce the prevalence of tobacco use in Karnataka, the manufacture, storage, sale or distribution of Gutka and Pan Masala containing tobacco or nicotine as ingredients, were banned vide Gazette Notification No.815, Part III, Bangalore, Saturday, June 1, 2013.
2. Introduced Online reporting of COTPA violations from District to State.
3. Identified 102 authorised officers for effective implementation of Tobacco Control Law(COTPA) in Karnataka.
4. Identified courts to take legal action under COTPA Section 5 and 7 in Karnataka.
5. "One State One Account" to deposit COTPA fine amount has been introduced for the accountability on fine amount and better utilization of fine amount for exclusively for Tobacco Control.
6. Bangalore Rural District declared as '**Smoke Free**' on December 3rd 2014 by honourable Health Minister.
7. E Cigarette was banned on 16th June 2016 under Drug and Cosmetic Act 1940.

8. Developed Mobile APP to reach the maximum public especially youths on tobacco control programmes and to register COTPA violation cases.
9. Bangalore International Airport has been made as "Smoke Free Airport".
10. Identified more than 20 new Tobacco Control champions and organizations and continue to explore more.
11. VAT increased from 17% to 20% during the year 2015- 16 FY.
12. Under National Tobacco Control Program, Tobacco Cessation centres have been opened in 14 district hospitals(Bengaluru Urban, Kalaburagi, Kolar, Yadgir, Koppal, Dharwad, Shivamogga, Tumakuru, Mysuru, Vijaypura, Belagavi, Gadag, Bellary, Bidar) and 4 districts are in the process of acquiring them.
13. As a part of IEC program, an innovative campaign to create public awareness on Ill effects of Tobacco Consumption and COTPA provisions 'Rose Campaign' has been conducted in Udupi, Hassan, Bagalkote and Bangalore Rural districts. This campaign has been applied for Pradhan Mantri award by Udupi District administration.
14. With the support from NIMHANS, Bangalore, an innovative program called **Virtual Knowledge Network Model** has been started to improve tobacco cessation services at District hospitals. One day training on Tobacco Cessation services were conducted in NIMHANS where 32 psychologists and social workers were trained. NIMHANS will give hand hold support to Psychologists once a fortnight through mobile app and video conference. After completion of six months online course, psychologists and social worker will receive a certificate.

IEC Programs:

In 18 districts, through wall paintings, hoardings, handouts, posters and stickers, public awareness has been created on ill-effects of tobacco. A media campaign was conducted from 25th March to 15th April 2017 throughout the State. Anti Tobacco Messages were displayed on TV, Radio, LED Screening in BMTC Bus Stands and 750 Theatres in Karnataka. A stall was put up at Bengaluru Health Festival.

School Awareness Program: Under National Tobacco Control Program 72 school programs have been conducted to educate and sensitize 14480 students on ill effects of Tobacco consumption.

Capacity Building of Officers:

Through Bloomberg Initiative Project, State Anti Tobacco Cell trained more than 6500 officers from State, District and Block levels from August 2014-April 2017 on Health Issues, COTPA implementation and DATC management.

Following key Capacity Building have been conducted for various stakeholders;

- Conducted two State level workshops and sensitized more than 100 officers from various departments.
- Conducted 42 high level District level Sensitization Workshops by involving Policymakers, Law Enforcers and Civil Societies and sensitized 2000 officers.
- Conducted 65 workshops for district level enforcement officers and trained 2500 officers.
- Conducted 120 DATC quarterly review meetings and monitored effective implementation of Tobacco Control under chairmanship of Deputy Commissioner.
- Conducted 30 sensitization workshops and sensitized 1050 Hotel and restaurants association members, lawyers, traders and tobacco vendor association members. As a result, we are successful in bringing down COTPA violations in bars, restaurants, hotels and other public places.
- Completed 36 Block or Taluk level Enforcement Officers workshops and trained 1260 officers. So, we were able to do grassroot interventions to bring COTPA compliance.
- Conducted 10 workshops for Municipal Corporations and trained 550 COTPA Enforcement officers.

Social Marketing of Signages:

It was a challenge to ensure display and availability of signage in all public place. Public place owners find it difficult to get specified signage. To address this, State Anti Tobacco Cell came up with a solution by identifying signage display vendors both at State and District levels. State Anti Tobacco Cell were able to display more than 50,000 signages through identified vendors throughout the state.

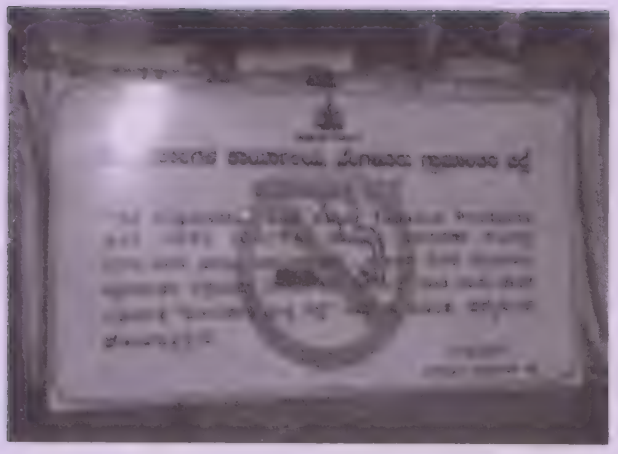

Figure 1: Bangalore Rural District declared as '**Smoke Free**' on December 3rd 2014 by honourable Health Minister.

Figure 1: Removal of Tobacco Advertisement

Figure 2: Display of COTPA Signage in PoS

Figure 3 Removal of Tobacco Advertisement

Figure 4 School Awareness Program under NTCP

Tobacco Cessation training for remote district counsellors by using digital technology: A Hybrid learning model

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Introduction:

Tobacco addiction is characterized by craving, tolerance, salience and continued use despite harm. Addiction actually develops as a result of Nicotine, which causes a transition from occasional smoking or chewing to a sustained habit.

Among persons who sought a health consultation, less than 50% were asked or advised to quit tobacco and less than 10% provided any form of counselling or pharmacotherapy. Providing simple counselling with proper use of pharmacotherapy, when required, is cost-effective in many Indian settings. One of the key areas of the National Tobacco Control Program (NTCP) is to help tobacco users to quit.

Tobacco Cessation Centre NIMHANS has designed a hybrid learning module with emphasis on connected learning for the remotely placed district tobacco counsellors so that they can assess the severity of tobacco use, understand concomitant physical and psychological comorbidities, offer personalized management plan and thereby provide quality care.

In this paper, the primary focus is on designing of the hybrid learning model and its implementation. The preliminary results and the challenges are also briefly highlighted.

Implementation

The Hybrid model used the principles of adult and networked learning and focused on case management i.e. learning by doing.

Figure 1: District Tobacco Cessation Centres (DTC) spokes connected to NIMHANS HUB)

Figure 2:Digital technology enabled Hybrid Learning for remote counsellors

Hybrid Learning

One day sensitization programme was held for 28 counsellors from 16 district tobacco cessation centres, at NIMHANS Bengaluru. on basics of tobacco dependence & related illnesses, assessment of tobacco use disorders and related conditions interviewing skills etc. followed by a curriculum was developed for next six months. The concept of digitally enabled hybrid learning was discussed.

a. Virtual Knowledge Network (VKN) NIMHANS ECHO

The heart of this NIMHANS ECHO model is its hub-and-spoke knowledge-sharing networks, led by expert teams from the NIMHANS who use multi-point videoconferencing to conduct virtual sessions with these counsellors. The ongoing fortnightly (2nd and 4th Wednesday between 11AM to 1PM) NIMHANS ECHO sessions consist of components of both **cases based learning** (i.e. case presentations by the district counsellors with guided practice by NIMHANS "hub") and **didactic sessions** by hub experts. The counsellors would present the clinical cases and the challenges that they are facing in the management of the patients. They would seek clarification regarding standard management from the NIMHANS multidisciplinary team as well as peers who have logged in simultaneously. This guided practice of patient management will strengthen the confidence and enhances the skills.

NIMHANS experts and taking opinion on best management practice followed by a brief didactic lecture

All participants had joined at least one virtual tele-ECHO sessions. Sixteen (59.25%) has joined three or more than three virtual sessions. Ten (37%) has joined only one session. There were 66 instances of participation accounting for 120 hours of training which include 15 case discussions for which expert opinions were sought and 3 didactic topics. Majority of cases (>70%) there were psychological and medical co-morbidities along with tobacco addiction and there is need to address those issues for holistic management.

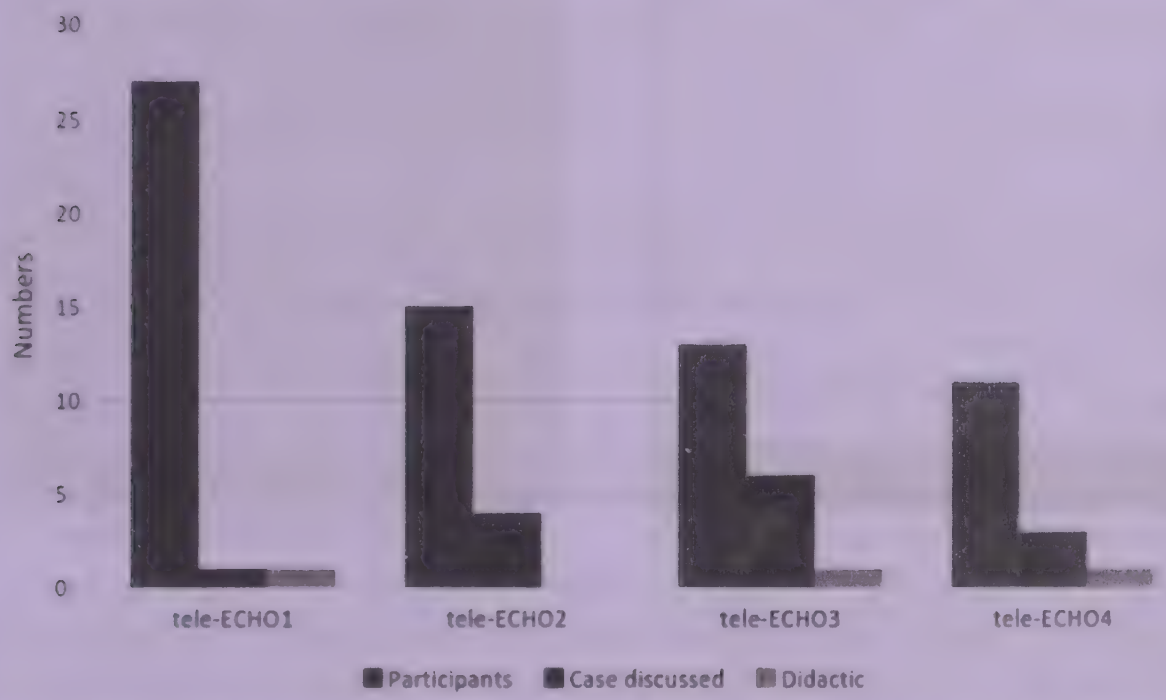

Table1:Level of participation and case presentation by the remote counsellors

(2). **Mobile based ubiquitous E-learning**

These Fortnightly tele ECHO sessions are linked to a monthly E-learning certificate module by a cloud-based learning management solution (LMS). This can be accessed anytime through desktop as well as the mobile app. The objective was to enable the counsellors to consolidate the knowledge and engage them in the learning process. Each assignment has a brief learning material in the form of video, text, photo and followed by a question (multiple choice, match the following or fill in the blanks etc.)

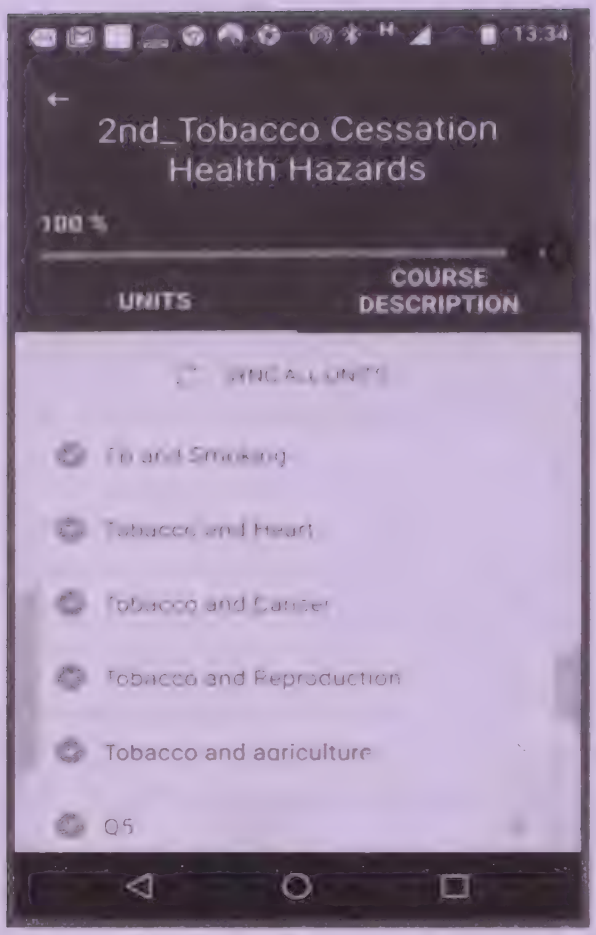

Figure4a: Mobile based learning assignment can be assessed anytime once a month

Figure 4b: Mobile based learning assignment can be assessed anytime once a month

Till now the results of two assignments were available. Assignment were completed by 75% (n=21) of total participants (n=28) in specified time duration, 10.71% (n=3) are not able to complete and 14.28% (n=4) did not attempt at all.

Social Media (Whats App):

Common WhatsApp group was also created and maintained by experts at TCC NIMHANS for easy communication either way along with full-time support system by the clinical experts.

Discussion:

In recent times with rapid strides in the educational technology, the learnings become more ubiquitous, personalized and accessible. In this study, an attempt was made to look at feasibility and acceptability of this innovative model of knowledge and skill transfer for the counsellors providing tobacco cessation services at distant districtsof Karnataka.

All the participants has joined at least one live virtual tele-ECHO session and 60 % more than 3 (out of 4),presented 15 patients for expert opinion and spent 120 hours of training indirectly suggest acceptance of this model of training. The joining to this hybrid learning was voluntary. Another indicator of the self-determined learning i.e. heutagogy was that 75% have completed e-learning assignments and majority through their smart phone during last two months.

Conclusion

In this preliminary study, multiple effective learning principles with humanistic approach (Kanuka 2008) i.e. freedom and autonomy, trust, active cooperation and participation, and self-directed learning have been used to sustain the motivation and engagement for the learners. From trainer and trainee perspective, this hybrid model gives an opportunity to use emerging pedagogies connecting formal (i.e. one day onsite), non-formal (virtual NIMHANS ECHO and e-learning), and informal educational contexts (social medial whats app) as a personal strategy that orchestrates life-long (overtime competence development and knowledge acquisition), life-wide (across social settings), and life-deep (beliefs and values) learning.

From the policy maker perspective, this is much more cost-efficient model rather than physically enrolling the counsellors into a traditional 6 months course in a centre. This is obvious by the fact that total budget excluding the cost of the time spent by NIMHANS HUB experts spent for this hybrid learning is 40000 INR.

Lessons learnt in implementation of this "HYBRID LEARNING"

1. Content: Development of relevant and appropriate content as per the need of the group as well as its delivery in local language specifically for mobile learning assignments.
2. Digital literacy: Choosing as well as adapting appropriate educational technology which is cost-effective and also user friendly both to the trainers (i.e. HUB experts) and the trainees (i.e. remote counsellors).
3. Engagement and motivation for continued learning

Acknowledgement

Thanks to Anti-tobacco Cell, National Health Mission and Project ECHO (Extension of Community Healthcare Outcome) USA to provide logistics to implement this initiative.

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Quitting Tobacco

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Introduction

Everyone knows that tobacco use is harmful. For decades, there have been slogans that one cigarette can reduce 5 minutes of your life, which has in recent times been increased to a loss of 6 minutes of one's life. Yet people continue to use tobacco. Although the recent National Family Household Survey suggests a small reduction in tobacco use, it is nevertheless a serious concern that people all over the country smoke or chew tobacco in various forms. In urban areas, smoking among women is more noticeable, as is the use among many young people, whose smoking has become visible as smoking is banned in educational institutions and workplaces.

The why and how of addiction

Here are some important facts that one needs to know about tobacco use.

Tobacco itself is addictive

All forms of tobacco contain nicotine, which is one of the most addictive substances known to human beings. Nicotine gives the brain a pleasant rush, which makes the person want to use to experience the high. Over time the brain adapts to the nicotine and the rush is not felt with the same amount of nicotine. So the person needs to use more tobacco in order to get this rush. When the person stops tobacco, there is no nicotine rush and the person experiences unpleasant withdrawal effects, including restlessness, irritability, low mood and difficulty in concentration. This would go away in a few days, but the accompanying craving that occurs draws the person back to using tobacco.

Proneness to tobacco addiction runs in families

It is well recognized that addiction to tobacco runs in families. A history of tobacco use and addiction should be a warning sign for young people not to use tobacco, as they already have a vulnerability to addiction.

However, even persons without a family history of addiction can become addicted to tobacco.

Does tobacco bust stress?

When a person uses tobacco, there is a sense of feeling more relaxed and calming down. Gradually, the person starts to associate such use with a feeling of relief from stress. Overtime, the person's only way of coping with stress becomes the use of tobacco. Tobacco is not an effective stress buster because:

- It is harmful to the body
- Over time the same amount stops working, and as mentioned before, the person needs to increase the dose for the same effect (tolerance)
- Since the source of the stress is not addressed, stress persists. In addition to the stress, the person now has two problems – stress and addiction to tobacco

Instead, it is more useful for the person to learn more effective ways of handling stress

Dealing with tobacco

The first decision making point is really never to use tobacco. This is possible when one is aware of the harm from tobacco use, makes an informed personal choice that he or she will not use tobacco.

If using tobacco, it is important to QUIT as soon as possible. Tobacco is known to cause a host of diseases, and stopping tobacco is one of the most important decisions to prevent diseases like heart disease, diabetes and cancer.

How to Quit

For a person who is not severely habituated to tobacco, the most important thing is to decide to quit. People find 'cold turkey' the more successful way to quit rather than a gradual taper. The first few days may be difficult, so the common advice to 'delay the urge', distract oneself while experiencing

craving, drink frequent sips of water and deep breathing are important tips during quitting. Keeping oneself busy, being in the company of non-users, having a regular diet and exercise, learning simple methods of relaxation to calm oneself are simple self-help strategies during the immediate post-quit phase. The other is to feel good about quitting – feeling like it is a positive achievement rather than having lost something.

Getting help

The wellknown quote, 'Quitting tobacco is easy. I have done it.....a thousand times before' aptly describes the difficulty in giving up any addiction. Tobacco addiction, much like any other drug addiction, is prone to relapse, even when a person is committed to quitting. Thus, for those who have found it difficult to quit, help is available. There are many medical and dental facilities which offer specialized treatment for tobacco addiction. For a start, any health professional should be able to help a person with severe addiction to quit tobacco.

What gets done?

The first thing that a health professional usually does is enquire in detail about the tobacco use habit. When it started, what were the circumstances of first use (peer pressure, curiosity, stress etc), how it progressed to addiction or dependent use, the current use patterns (type of tobacco, mode of use, frequency and last use), health and psychological effects of use, family history of tobacco and other addiction, the individual's temperament (ability to handle stress, prone-ness to anger, mood swings, anxiety etc). The health professional will also seek a medical history of disorders that can be associated with or aggravateby the use of tobacco.The next step is a detailed physical examination for any clinical signs of underlying health problems.

Initiating tobacco cessation includes telling the user of the harm that has occurred, the harm that is likely to occur from continued use and the benefits of quitting tobacco. The health professional explores with the user the perceived benefits of tobacco, the possible benefits of quitting, the reasons for quitting as well as the fears of quitting (concerns about craving, boredom, loss of friends, difficulty in concentrating etc). The health professional then gently nudges the tobacco user in the direction of wanting to quit by discussing both the benefits and harms of use, and the benefits of quitting.

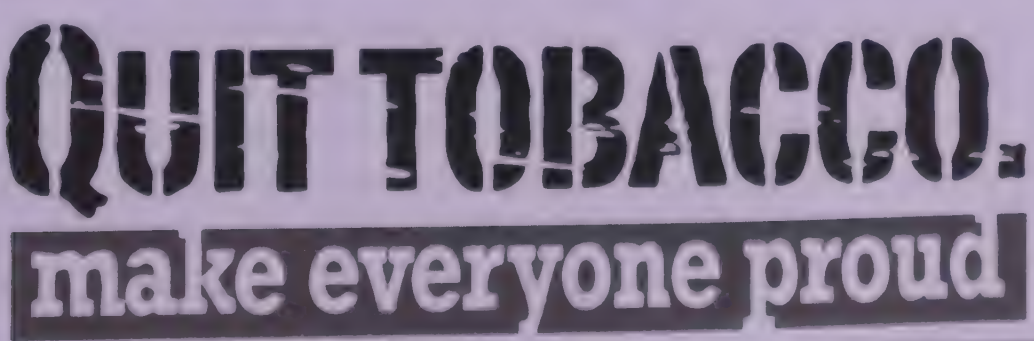
There are presently many pharmacological aids to quitting along with the counseling. These include Nicotine Replacement Treatments (NRTs). The principle of NRT is to replace the unsafe tobacco that the individual was using (which has many toxic substances, including cancer producing ones) with pure nicotine so that withdrawal symptoms can be handled, and gradually tapering the dose of nicotine at the quitter's pace. NRT is most easily available in the form of gums and patches in India. Since NRTs work just like tobacco, the tobacco user can directly switch from tobacco use to NRT. NRT is usually prescribed for 3 months, but may be required for several months to years to kick the tobacco use habit.

The other pharmacological approach is non- NRT medications. Bupropion, nortryptiline and varenicline are the most commonly used medicines for tobacco cessation. Here the medicine is started while the person is using tobacco and the person sets a total quit date about one to two weeks after initiating the medicine. The person can than at once stop any tobacco use, and the medication will help to minimize the withdrawal effects. Such medication is also usually prescribed for 3-6 months.

While the person is using the NRTs, he/she also learn to plan a tobacco-free life by learning the skills that will help to reduce the risk of relapsing to tobacco (dealing with craving, anxiety, low mood, pressure to use tobacco etc). Some of the fears like weight gain, tension etccan also be reduced by discussion with the health profession

Health Professional's role in tobacco cessation

Every health professional must make their patients aware of the harm from tobacco and the importance of quitting. They must encourage the tobacco user to quit and provide support to the tobacco user for cessation. Persons who are unable to quit despite attempts to quit may be referred to tobacco cessation clinics, now available in many hospitals.



GLOBAL IMPACT OF TOBACCO ON HUMAN, ECONOMIC, ECOLOGICAL SYSTEM

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Introduction

Tobacco is neither human friendly nor environment friendly. In fact it is the chief avoidable cause of premature death and illness. According to WHO estimation, over 10 million people die of tobacco related diseases every year all over the world. The impact of human tragedy on family in particular and society in general is unimaginable. The ecological and economic impact is unfathomable and mind boggling. It is high time the public and politician woke up to this burning problem.

Economic impact

The tobacco industry which is made to appear as a good source of revenue by the successive governments is in fact responsible for more financial burden. 25% of health expenditure in USA is on tobacco related diseases and it stands at staggering 6.5 billion dollars/year. Financial burden on government in treating tobacco related diseases in India is not known. A smoker smoking 20 cigarettes a day spends Rs. 10,950/year. That means for 30 years of smoking he spends Rs.3, 28, 5000 which otherwise could have been used to build a house or educate the children and get them married. Economic impact of disease and death due to tobacco is incalculable.

Human tragedy

Tobacco a prime killer in prime of life, kills more than 8,00,000 people every year in India, where as death toll due to road accidents is around 60,000 per year. 25% of fatal heart attacks are due to tobacco consumption. Over 20,000 people undergo amputation (cutting limbs) annually. More than the medical expenditure, for treatment & cost of artificial limb, the burden of the crippled man on the hapless family is unbearable. About 50% of cancers in man and

25% of all cancers in women are directly due to tobacco. It is estimated that 60% of all the lung diseases like bronchitis, emphysema are due to smoking. The paralysis (stroke) is 3 times more common in smokers than in non-smokers. The paralyzed man is like a living dead or a vegetable neither useful to his family nor the society. The human tragedy and the consequences in the family of the dead or paralyzed or crippled with amputation are incalculable.

Ecological impact

Curing of 1 kg of tobacco for cigarette needs 5.6 to 8 kgs of air dried wood. Curing of 1 tonne of tobacco needs 118 trees sacrificed. What is more distressing is 76.2% cigarette tobacco is cured by cutting indigenous fruit & neem trees. Just imagine, it takes 20-40 years to grow a tree before it is sacrificed within 20 minutes for curing tobacco! Not only the ecologist but every sane person must be disturbed to know that one hectare of tobacco grown needs 2.18 hectares of forest wood. The tobacco causes twice the amount of land erosion as compared to food crop. The tobacco needs thrice the amount of fertilizers as compared to food crops. Almost 40% of land used for tobacco cultivation is irrigated land where one can reap 3-4 food crops instead. The cost of irrigation is about Rs. 36,000 per hectare. More than irrigation the large amount of even subsoil water is drained by tobacco. The consequences of depletion of forest and the trees are terrifying especially when everywhere there is scarcity of rains. Though it is called as a "cash crop" in fact it is a 'crash or crush crop' as it crashes the health of human being and has crushing impact on ecology and economy.

Heart & Tobacco

The heart is the most wonderful pump in the world. It starts beating in the mother's womb when the foetus is just 6 weeks old and continues to work without rest till our dying day. Every minute it pumps about 2-5 litres of blood into the blood vessels (tubes carrying blood to the nook and corner of the body) which when stretched in line extends upto 60,000 miles. Every day the heart pumps 2500-5000 gallons of blood. The fuel required to pump 5000 gallons of liquid is equal to the fuel required by Queen Elizabeth's ship to sail from London to New York and back. Like any other muscle the heart depends on a constant supply of oxygen to sustain activity. So its fitness in turn depends on or is linked with the lungs. Such a powerful heart can be diseased by tobacco. Not only the heart but even the blood vessels carrying blood develop multiple blocks leading to gangrene of limbs, stroke and heart attack.

What are the harmful effects of Tobacco?

Tobacco contains over 4000 chemicals; about 40 of them are cancerous. But most dangerous substances are three:-
(i) NICOTINE – a highly addictive toxic substance, which diffuses very quickly into the blood stream providing a quick fix to the smoker. One cigarette contains 1 mg of Nicotine and when taken as injection intravenously is fatal. But when a person is smoking he hardly takes 15% of Nicotine in that cigarette but still each cigarette reduces the life span of the smoker by 10 minutes. Nicotine causes spasm (or narrowing) of the coronary arteries (blood vessels supplying blood to the heart). It also increases the heart rate and causes blocks in the coronaries leading to heart attack and death.

(ii) Carbon Monoxide (CO) - is the 2nd most dangerous substance in tobacco which damages both heart and lungs. When CO is absorbed into the blood stream it binds to Hemoglobin, reduces oxygen, causes heart and arterial disease.

(iii) TAR - is solid irritant that coats the lungs, blocks the airways and cause emphysema and lung cancer.

Smoking and Cardiovascular disease (CVD):
In the western developed countries death rate has come down by > 28% by public awareness and bringing down the rate of smoking. It is well known that Nicotine and Carbon monoxide are the main culprits. Death rate for all CVD for smokers is 2-3 times that of non-smoker and 35-40% of the deaths occur before the age of retirement (Royal college of Physicians, 1983) that means the person dies in the prime of life before fulfilling his domestic duties. Smoking is associated with both aspects of atherosclerosis (a) promotes development of lesions thus creating sites susceptible to blockage,(b) promotes the occurrence of triggering events that lead to blockage (US, Department of health and Human Services 1989).

Recently, evidence shows linking of passive smoking to CVD. One may ask what is passive smoking?

Smoking has (a) Main stream - that is inhaled and exhaled by smoker and a (b) Side stream – smoke from the burning tip of the cigarette. 85% of tobacco

smoke in the room is from side stream and this smoke contains higher potion of toxic gases. Passive smoking is breathing other people's tobacco smoke from side stream and is a cause of health hazard in innocent non smokers (US dept. of Health & Human Services,1986).

What is the treatment for blocked arteries?
We can keep balloon across the blocked artery and inflate it to open the block called angioplasty or PTCA. To reinforce or strengthen the wall, steel mesh called "stent" can be deployed. If blocks are multiple then bypass surgery can be done. But the treatment is expensive and carries some morbidity and mortality. Hence it is important not to smoke. All the three main components of smoking – physical, chemical addiction and psychological dependence should be tackled in an attempt to quit smoking.

Key points:

1. Smoking can kill you by many ways – by heart attack or stroke or cancer or gangrene.
2. Smoking not only kills the smoker but also the people around him.
3. Smoking destroys the family, society, ecology and economy of the country.
4. Tobacco is neither human friendly nor environment friendly. So it is neither humanity nor sanity.
5. STOP THE HANDS THAT MAKE THE CIGARETTE AND ALSO THE HANDS THAT LIGHT THE CIGARETTE.
6. Smoker can be described as fool at one end and fire at the other end.

Is India sincere in fulfilling FCTC protocol?

Vasanthkumar Mysoremath
Convener, Anti-Tobacco Forum and
Hon. Adviser, Cancer Patients Aid Association
World Bank Honoured Innovator

- Activists skeptical about reduction in consumption of tobacco
- 85 per cent space reservation on packages is just another theme
- India is adopting dual policies in tobacco control
- Tobacco farmers are worried about their future
- Want to give up tobacco farming and adopt equally remunerative alternate crops
- They are yearning for hand holding by Government

World Health Organisation's Report:

Is India really serious about fulfilling its obligation under FCTC protocol?

While India may appear to be well ahead of many other signatory countries to the FCTC in tobacco control efforts, a reality check of how India does not appear to be sincere is reviewed here.

India appears to be adopting a 'please all' policies in contravention of Guiding Principle 4 of Article 5.3 that prescribes "because their products are legal, the tobacco industry should not be granted incentives to establish or run their business; any preferential treatment extended to the tobacco industry would be in conflict with tobacco control policy".

A reality check of compliance of Article 5.3 reveals a shocking flagrant violation and contradictory actions by the Government of India and its agencies for helping tobacco industry to grow with Government subsidies:

(1) Supply of inputs, farm mechanisms, fertilizers and equipment for improvising yield and quality, improving of curing practices, extension programs, incentives to tobacco farmers, tax cuts and tax exemptions and other benefits. During 2012-13, the Tobacco Board provided subsidies to the tune of Rs.3.73 crores.

(2) In 2001-02, Karnataka had 18,751 licensed tobacco growers with 25,207 barns; area permitted: 29,852 ha but actually cultivated area was 47,699 ha. But in 2011-12, the number of tobacco farmers with licenses increased to more than 41,737 with 57,512 barns, area permitted 80,516 ha but actually cultivated was 1,18,989 ha. This resulted in more than 100 per cent in all areas of tobacco production. In addition, the Tobacco Board has decided to renew lapsed licenses, allow procurement of excess grown quantity as also illegally cultivated tobacco for auction in its platforms built with public money. Whither FCTC?

(3) Under FCTC article 5.3 guidelines, there should not be any conflict of interest for Government and Government officials; but more than Rs.3,500 crores of insurance funds of Life Insurance Corporation and its subsidiaries and of Unit Trust of India have been invested in shares of a tobacco major in India in addition to holding of more than Rs.50 crores in shares of other tobacco industries that manufacture chewing tobacco. Further, Government officials must not take active part in any activity organized by the tobacco industry or related institutions and must not receive any kind of gift, in cash or kind but many elected representatives and government officials open take part in events organised directly/indirectly by tobacco companies or tobacco farmers associations.

(4) Interference in policy making by Public officials: Many Ministers, Members of Parliament and Members of State Legislature and their families have financial interests while simultaneously having a say in tobacco-related policies of Government; examples: a 'Bidi King' was a Central Minister between 2004-2014 and two MPs – one a tobacco exporter and another a areca nut trader were simultaneously members of Standing Committee on Finance in 2009-2010. Similarly, the Standing Committee on Subordinate Legislation on tobacco products packaging policy had an MP who was the owner of a major bidi manufacturing company, as Member. In another example, when the Ministry of Health proposed ban of loose cigarettes, a Minister in the present Government, who is part of the Beedi industry and also a member of Sub-Committee of the Tobacco Board was successful in getting the subject referred to an inter-ministerial committee (idea was to stall its implementation).

(5) Tobacco industry interference is evident from its proposing to partner with Governments on civic issues that appear unrelated to tobacco control (idea is to promote the brand image of a tobacco company and also provide tobacco representatives with easy access to policy makers/Government

officials); example: The Bruhat Bengaluru Mahanagara Paalike (BBMP) which hosts Anti-Tobacco Cell for Bengaluru urban district itself partnered with India's top tobacco company for a "Zero Garbage Project". In 2011, Government of Meghalaya signed an MOU with a major gutka manufacturing company for setting up cement plants in Meghalaya.

(6) Many countries have enacted codes of conduct and legislation to govern conflicts of interest of Government and public officials to minimize conflicts of interest in the discharge of their official duties, laws and policies rejecting monetary donations and divesting any existing funds in the tobacco industry.

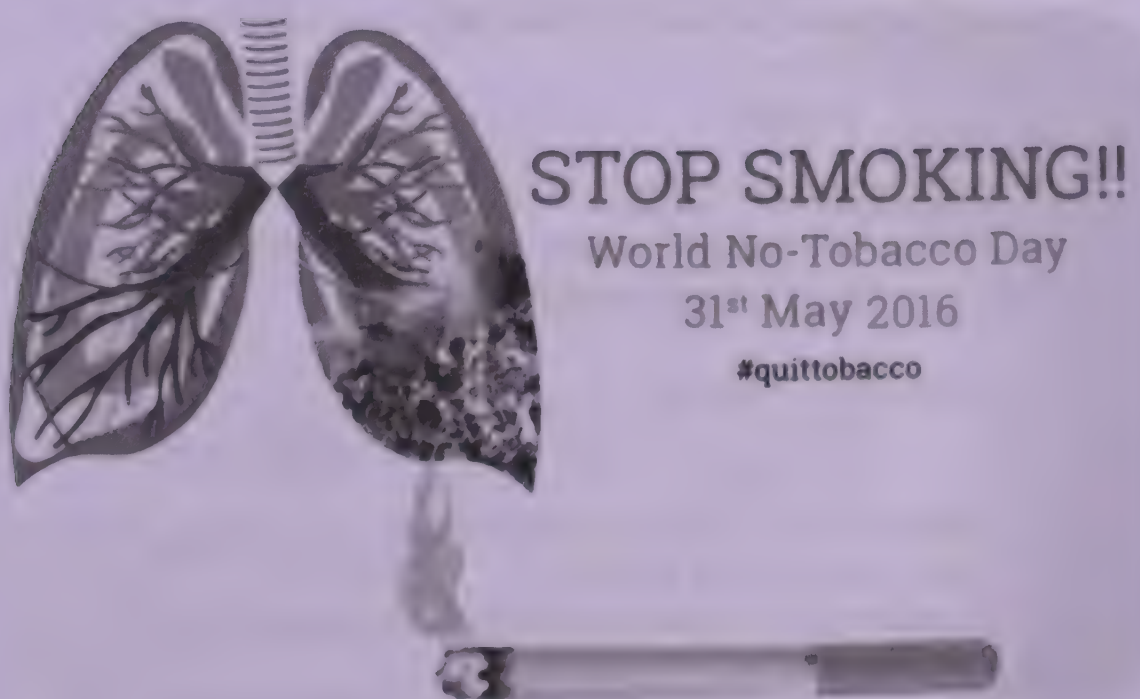
- Canada's Conflict of Interest Act 2006 has laid down rules and regulations for public officials during their period in office;
- In Kenya, Tobacco Control Act 2007 prohibits any member of Tobacco Control Board to be affiliated to any tobacco industry;
- In Namibia, no official of Tobacco Products Control Committee must involve in cooperation with any tobacco industry and must not have any shares in any business etc;
- In Portugal, no member of National Scientific Tobacco Prevention Board should have any affiliation and tobacco industry cannot sponsor any activities that directly or indirectly promote a tobacco product.
- In Tasmania, political donations by tobacco industry business entities is unlawful (In India, most political parties and politicians accept donations and are also exhibiting the amounts received in their tax returns).
- In Norway, tobacco companies have been excluded from investment universe of the Government Pension Fund Global.
- Australian Federal Government's Future Fund has decided to get rid of its investment in tobacco companies and Australian National Tobacco Strategy (2012-2018) has excluded tobacco industry's exclusion from investment propositions.
- Canada: Government of Alberta Province has directed its Investment Management Corporation to sell-off its direct ownership of tobacco companies.
- Hongkong: The Monetary Authority of Hongkong has committed to divest its holding in tobacco companies as also the Hong Kong Mandatory PF Schemes Authority; the HMA has gone one step forward and instructed its various contractors also to divest their holdings in tobacco companies.

Recommendations for effective tobacco control:

(1) Tobacco Board Act has to be repealed and the Board disbanded since its vision, mission and charter of demands are contradictory to FCTC protocols. Create a separate Tobacco Cell within the Ministry of Commerce for coordinating tobacco control programs with transparency and accountability.

(2) In view of increased Anti-Tobacco and health awareness activities all over the world, tobacco farmers are confused and many who are expressing their concern and anxiety about their future livelihoods; they and their associations office bearers are demanding intervention by Government for hand holding by way of extending technical and financial support so that they can surrender their barns, enrich their depleted soil conditions due to continuous farming of tobacco etc. Money can be found for helping them through immediate divestment of shares held by various Government financial institutions and departments in tobacco companies; this would result in availability of enough money for creating a corpus for rehabilitating the farmers and other labor engaged in tobacco industry.

(3) Enact strict laws to prevent tobacco industry interference in law/policy making, stop brand recognition activities under the guise of Corporate Social Responsibility with demand for



World No Tobacco Day, 31 May 2017
Tobacco – a threat to development

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Every year, on 31 May, WHO and partners mark World No Tobacco Day (WNTD), highlighting the health and additional risks associated with tobacco use, and advocating for effective policies to reduce tobacco consumption.
The theme for World No Tobacco Day 2017 is "Tobacco – a threat to development.

Tobacco is the killer its use can be prevented. Knowing the facts about the damage it is doing we can involve the public and send the message across. Be aware to be healthy.According to WHO

More than 7 million deaths from tobacco use every year, a figure that is predicted to grow to more than 8 million a year by 2030 without intensified action. Tobacco use is a threat to any person, regardless of gender, age, race, cultural or educational background. It brings suffering, disease, and death, impoverishing families and national economies.

Facts about smoking:-

- 1/3rd of world population-Smoker
  - Males: > 1 billion
  - Females: > 250 million
- Industrialized Countries
  - % of Male smokers: 50%
  - % of Female smokers 22%
- Developing countries
  - Males 35%
  - Females 9%
- Three millions death annually because of smoking, means one death after every 8 seconds.
- 10 millions death anticipated by 2020, means one death after every 3 seconds.
- Developed countries have reduced smoking by 10% and developing countries have increased by 60% after 1970.

Types of tobacco smoking

- Cigarette - Most common and most harmful
- Sheesha
- Bidi
- Tobacco chewing
- Hookah(Hubble bubble)
- Cigar
- Kreteks(clove cigarettes)
- Snuff – Moist & Dry
- E-cigarette

Causes of smoking

Usually the adolescents (mostly of 10-15 yrs) indulge in smoking as a result of

- Curiosity,
- Adventurism,
- Rebelliousness and adulthood,
- A manly and masculine act that will lead them to happiness, fitness, wealth, power and sexual success.
- Attractive advertisements influence the immature and unstable minds.

Composition of tobacco

- About 4000 toxic substances are present in tobacco
- Most important and dangerous constituents:
  - Nicotine
  - Carbon Monoxide
  - Tar

Effects of Nicotine

- Smokers have to maintain a level of nicotine in the blood for normal working.
- Smokers have to smoke to avoid the discomfort experienced while not smoking

Consequences of smoking

- Economic loss
- Health loss
- Socio-cultural loss
- Psychological loss

Smoking and Diseases

- An important causative/risk factor for various diseases.
- About 25 diseases caused/aggravated by smoking. e.g.
    - Lung cancer: 80-90% deaths due to smoking. Incidence 10 times more than non-smokers.
    - Chronic bronchitis
    - Emphysema: 80- 95%
    - Ischaemic heart disease: 20-30% deaths . Risk is twice than non-smokers
    - Obstructive peripheral vascular disease

Smoking and diseases

- Cerebrovascular disease
- Cancer of tongue, oesophagus, larynx & pancreas, Gastro-duodenal ulcers
- Cancer of the cervix and endometrium
- Cancer of the urinary bladder
- Still births, abortions
- Neonatal deaths
- Fracture of hip, wrist and vertebrae

Smoking during pregnancy

- Foetal retardation and growth retardation in the children.
- Children of smokers are more prone to become smokers later on.

Effects of Second Hand (Passive) Smoking(SHS)

- Children
    - Sudden infant death
    - Respiratory distress
    - Otitis media
- Adults
    - Leads to discomfort, distress to asthmatics
    - Nicotine is detected in blood and urine of passive smokers.
    - Passive smoking by adults may lead to Ca-cervix, CA lung, and coronary heart disease.

TOBACCO & ORAL HEALTH IMPLICATIONS

- Leukoplakia
- Nicotine palatinus (stomatitis).
- Smokeless tobacco keratosis
- Submucous fibrosis
- Hairy tongue.
- Gingival & alveolar bone damage

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Treatment

- Drugs
  - Nicotine replacement therapy
    - Patches
    - Gums
    - Nasal sprays
    - Inhalers
    - E-cigarettes
  - Hypnotics
- Group therapy

Real Treatment is by

- Motivation
- Commitment
- Determination and
- E□ort and support in the struggle to quit smoking.

Preventive measures

- Recommendations of WHO Framework Convention on Tobacco Control (FCTC) should be implemented.
- Govt.'s responsibility for implementation of recommendations and legislation.
- Ascertain the existence of smoking as health problem.
- Encourage not to start smoking.
- Encourage to stop smoking.
- Multi-sectoral approach.
- Anti-smoking health education to general public but special emphasis to focus on children and to the occupational groups.
- Highlighting the positive e□ects of *NOT* smoking and *QUITING* smoking.
- Awareness for the rights of non-smokers.
- Legislative action

To summarize, tobacco should be completely eradicated in a city as a whole. Considering the amount of damage its causing on the over all health of a person the far reaching e□ects of its decline in use will considerably have a positive e□ect on the society

Lets all get together to create awareness about tobacco and its harmful a□ects .

Members of Consortium for Tobacco Free Karnataka

- State Anti Tobacco Cell
- Tobacco Cessation Clinic, NIMHANS
- Bangalore Medical College and Research Institute
- Kidwai Memorial Institute Oncology (KMIO)
- Government Dental College and Research Institute , Bengaluru
- SOCHARA, Bengaluru
- Institute of Public Health, Bengaluru
- St. Johns Research Institute, Bengaluru
- The Bangalore Baptist Hospital
- Centre for Law and Policy Research (CLPR)
- Oxford Dental College, Bengaluru
- R V Dental College, Bengaluru
- M S Ramiah Dental College and Hospital, Bengaluru
- Cardiologic Society of India, Karnataka Chapter
- Narayana Health, Bengaluru
- HCG Cancer Hospital, Bengaluru
- Karnataka State Resident Doctor's Association
- Indian Medical Association, Karnataka